Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125052	A. BUILDING: ______ B. WING ______	08/31/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF KONA	78-6957 KAMEHAMEHA III ROAD KAILUA KONA, HI 96740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 000	Initial Comments A state re-licensure survey was conducted at the facility from August 28, 2018 to August 31, 2018. On entrance, the census included 80 residents.	4 000		
4 159	11-94.1-41(a) Storage and handling of food (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. (1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and (2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage. This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure proper hand-washing procedures are followed when passing out meal trays and beverages to prevent cross-contamination of bacteria and viruses to residents. Findings include: On 08/28/18 at 11:31 AM on Ocean View Hallway observed Certified Nurse Aide (CNA)33 passing lunch trays and hot cocoa to residents in their rooms without sanitizing her hands between each resident contact. When CNA33 was queried about the proper way to distribute food to residents, she verbalized she should have sanitized/washed her hands before and after each resident served. CNA33 was observed to continue passing trays without proper hand	4 159	Tag: 812 Corrected Action: CNA #33 Educated on proper hand washing techniques while passing hall trays. Identification other areas affected: Random audit conducted during hall tray pass to ensure proper hand hygiene is being followed. Systemic Changes: Nursing staff educated on proper hand washing techniques during meal tray pass. It is facility policy to maintain infection control standards by washing or using sanitizer between taking meals to each	11/2/18

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4 159	Continued From page 1 sanitizing/washing. On 08/31/18 at 09:20 AM interviewed Licensed Nurse (LN)26 who stated staff should already have the knowledge about proper hand sanitizing/washing technique for food distribution. On 08/31/18 at 10:31 AM interviewed the Director of Nursing (DON) who confirmed that CNA33 had her hand hygiene training class (Certified Nursing Assistant Competency/Skills Checklist) on 08/17/16. There were no annual updates for hand-hygiene in-service attended by CNA33.	4 159	resident and before entering and upon leaving a residents room. Monitoring: Weekly audits will be conducted by designee for the first 4 weeks and then monthly audits conducted by designee for the next 3 months to ensure proper hand washing is performed before and after each Resident meal tray. Audits will be reviewed for any negative findings and presented to the QAPI committee for ongoing oversight.	
4 190	11-94.1-46(g) Pharmaceutical services (g) Each drug shall be rechecked and identified immediately prior to administration. This Statute is not met as evidenced by: Based on medical record review (MRR) and staff interviews the facility failed to ensure that the Pharmaceutical Services process was monitored to ensure accurate interpretation and reconciliation of prescriber's orders for 1 of 39 residents, Resident(R)36, on the sample resident list. Findings include: On 08/30/18 at 09:04 AM reviewed R36's medication orders for unnecessary medications for use of the anticoagulant medication, Warfarin. In the August 2018 medication orders, there is one medication order for Warfarin and in the September 2018 medication orders there are two medication orders for Warfarin; the first dated 07/23/2018 Warfarin 1 mg tablet administer 1 1/2 tabs equals 1.5 mg by mouth daily, and the	4 190	Corrected action: Resident # 36's September 2018 MAR was corrected to ensure there is only one current and correct Coumadin order. Identification of other areas: Facility wide Coumadin audit was completed for residents receiving Coumadin to ensure each resident is receiving the correct dose of Coumadin and no other residents are affected. Systemic: SDC or designee educated nursing staff on the procedure for doing end of month recaps to ensure discontinued orders are not missed during end of month	11/2/18

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4 190	Continued From page 2 second dated 08/13/2018 Warfarin 2 mg tablet by mouth daily. On 08/30/18 at 09:35 AM interviewed Licensed Nurse (LN) 17 who signed that she double-checked R36's September 2018 medication orders. Inquired of LN 17 why R36's September medications orders had two different orders for Warfarin when the previous August 2018 medication orders had only one order for Warfarin. Also inquired which Warfarin order was discontinued on 08/27/18, as new order for 1.5 mg Warfarin was written on that date. According to LN 17 the monthly medication orders was printed out by medical records staff and LN17 did double check on 08/29/18. LN pointed out that Warfarin 2 mg tab by mouth daily was written on 08/13/18. Queried LN17, that on 08/27/18 Physician/Prescriber telephone order was written to discontinue previous Warfarin order, and whether the 08/13/18 Warfarin order was the previous order. LN 17 could not provide an answer because she was on her way to start work at another unit. On 08/30/18 at 10:07 AM interviewed R36's Primary Care Physician (PCP) and Advanced Practice Registered Nurse (APRN) to inquire whether they wanted R36 to have increased Warfarin doses of 1.5 mg and 2 mg beginning September 2018 as medication orders printed and in R36 medical record. The APRN stated that she was more familiar with R36 and that the 2 mg dose was discontinued on 08/27/18 and the printed medication order was in error. The PCP stated that he did not sign to endorse R36's medication order that was double checked and signed by LN 17 on 08/29/18. The PCP further stated that printed medication orders, and	4 190	changeover. The requirement based on facility policy is: double check end of month POS with new orders in chart and double check all orders on MAR are current and correct, and there are no duplicates prior to signing off the "POS" (physician order sheet). Monitoring: DON or designee will audit the MAR of resident's who take Coumadin to ensure the current order with correct dose is on MAR. Audit will occur weekly x 4 weeks and then monthly x 3 months and results will be presented monthly at QAPI meeting for ongoing oversight.	

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4 190	Continued From page 3 Physician/Prescriber telephone order slips are "old-fashioned," and thankful that error was spotted. The APRN immediately crossed off order for 2 mg Warfarin on the Sept 2018 medication orders and initialed the order to endorse it. On 08/31/18 at 08:14 AM interviewed Licensed Nurse (LN) 22 to review R36's MAR for Sept 2018 and was directed to look in Medication Administration Record (MAR) binder for September. The MAR for R36 had two orders of Warfarin and inquired of LN 22 if MAR and Physician Orders are double checked before administering medication. LN 22 stated that nurses are scheduled to do double check between medication orders and MAR and the schedule was at the unit nurses station. The Minimum Data Set Coordinator (MDSC)2 reviewed the Medication Administration Record (MAR), printed medication orders and schedule for nurses to do double check. On the schedule for nurses to do MAR double check, R36's room number was crossed off. MDSC2 stated that LN 22 was assigned to do double check between MAR and printed medication orders but wasn't sure if crossed out room number reflected that LN22 had completed the double check. The Director of Nursing (DON) explained the medication order error and stated that Warfarin order on the Sept 2018 printed medication order and MAR would have been caught by Warfarin flow sheet that is used alongside the MAR. According to DON, although the Sept 2018 MAR was printed and in the binder the final checks are done by the night shift nurse, and error would have been noticed the night before the next month's medication orders began.	4 190		

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4 190	Continued From page 4 The facility's policy and procedures for Warfarin double checks were reviewed, it was noted that a Warfarin audit tool is used, and results reported to the Quality Assurance Performance Improvement (QAPI) committee. Requested from the administrator any Warfarin Quality Assurance (QA) reports from last 6 months. The DON provided Warfarin audit done in Aug 2018 and stated that Warfarin audit tool use started in August 2018. The DON did not analyze any data collected up to this date but did address a Warfarin error for R36, ("nurse did not call MD/NP with a below therapeutic level, checked today 8/9 - in therapeutic range.") The facility staff had multiple opportunities during double-checks on telephone orders, medication orders and MAR, but still included the 2 mg Warfarin order for R36, that should have been discontinued on 08/27/18.	4 190		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a PRN (as needed) medication label was changed to reflect the current physician's order to be administered as a scheduled, routine medication four times daily, for Resident(R)9 selected for review. This deficient practice had the potential to affect other residents for whom physician order changes were	4 197	Tag 0761: Corrected action: LN 13 immediately corrected medication blister pack for Clonazepam with a dosage change sticker. Identification of other affected areas:	11/2/18

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4 197	Continued From page 5 not accurately reflected on the medication label as well as parameters to hold the medication. Findings Include: On 08/30/18 at 7:51 AM, the licensed nurse (LN) 13 was observed passing medications to R9. LN13 poured the Clonazepam 0.5 milligram (mg) tablet out of the blister pack and into a medication cup. Review of the blister pack found the label had with Clonazepam to be given twice daily PRN for involuntary movement. LN13 was asked about the PRN dosing because she said it was to be given four times daily. LN13 reviewed the electronic medication administration record (e-MAR) on her cart and confirmed there was a new physician's order on 08/22/18 which changed the Clonazepam 0.5 mg to be administered as a scheduled, routine medication four times daily. LN13 verified the label on the two blister packs for the Clonazepam was inaccurate as it was no longer a PRN medication. Record review found the 08/22/18 "Physician order #105" which stated, "Clonazepam 0.5 mg tab P.O. (orally) four times daily hold for dizziness or unsteady gait." There was a failure by LN13 to ensure the correct dosing instructions for the Clonazepam also included the precautionary instructions to hold the medication for dizziness and unsteady gait.	4 197	Facility wide audit of medications with dose changes on current MAR compared to blister packs to ensure dosing instructions match MAR and blister pack. Systemic change: SDC or designee educated LN's to ensure dose change sticker is placed on blister pack when an order is received to change dosage of a medication. The nurses are responsible for putting on a dose change sticker at the time order is received and processed to alert of the medication dosage change. Dose change stickers are in the medication carts. Monitoring. DON or designee will audit for medications with dose changes to ensure medications with a dose change have a dose change sticker on the blister pack. This audit will occur monthly x 3 months and results will be forwarded to QAPI committee for ongoing oversight.	